‘I’ve got lots of gaps, but I want to hang on to the ones that I have’: The ageing body, oral health and stories of the mouth

ABSTRACT

The mouth may be presented and understood in different ways, be subject to judgement by others, and as we age may intrude on everyday life due to problems that affect oral health. However, research that considers older people’s experiences concerning their mouths and teeth is limited. This paper reports on qualitative research with 43 people in England and Scotland, aged 65-91, exploring the significance of the mouth over the life course. It uses the concept of ‘mouth talk’ to explore narratives of maintaining, losing and replacing teeth. Participants engaged in ‘mouth talk’ to downplay the impact of the mouth, demonstrate socially appropriate ageing and distance themselves from ‘real’ old age by retaining a moral identity and sense of self. They also found means to challenge dominant discourses of ageing in how they spoke about missing teeth. Referring to Leder’s (1990) notion of ‘dys-appearance’ and Gilleard and Higgs’ (2013) work on the social imaginary of the fourth age, the study illustrates the ways in which mouth talk can contribute to sustaining a sense of self in later life, presenting the ageing mouth, with and without teeth, as an absent presence (Rousseau *et al*. 2014). It also argues for the importance of listening to stories of the mouth in order to expand understanding of people’s approaches to oral health in older age.

KEYWORDS - Dys-appearance, Embodiment, Fourth age, Identity, Life course, Mouth talk, Narrative, Oral health.

Introduction

Twenty-first century Western society is obsessed with youthfulness, while ageing bodies represent 'ugliness, degeneration and moral failure' (Bond and Cabrero 2007: 117). Featherstone and Hepworth (1991; 2005) have described a reflexive process, whereby people evaluate the ageing of their own bodies according to dominant cultural ideas of physical attractiveness. Older people take on the judgements of others when making sense of their own self-image (Faircloth, 2003; Clarke and Griffin 2008; Warren and Richards 2012), as evidenced in research on embodied practices including styling and colouring hair (Ward and Holland, 2011), putting on lipstick (Clarke and Bundon, 2009) or getting dressed (Twigg 2007).

The appearance of one's teeth can be seen as socially symbolic and subject to judgement from others (Khalid and Quiñonez, 2015). The appearance of natural teeth or dentures is a body project, achieved through self-care regimes and cosmetic modifications (Shilling, 2003). As such, teeth are subject to body work (Gimlin, 2007a) by both patients and dental professionals. Nettleton (1992) has demonstrated how the mouth emerged as an object of dental practices, the patient expected to take responsibility for their oral health. We need to consider what this means for older people in relation to changing ideas of what constitutes acceptable oral health through the life course.

Leder argues that typically the body is not the thematic focus of our experience of the world; while 'in one sense the body is the most abiding and inescapable presence in our lives, it is also essentially characterized by absence' (1990: 1). At times though, the body does appear in thematic focus, but in a 'dys-functional' or problematic state, due to pain or disease: it 'dys-appears' (*ibid.*). Qualitative dental research shows how problems with the mouth and teeth can intrude on everyday life, whether due to particular health conditions, such as chronic dry mouth

(Owens *et al*. 2014), or to missing teeth (Rousseau *et al.* 2014). For older people, various routes lead the mouth to become 'a cause of chronic annoyances that warrant[ed] constant vigilance' (MacEntee *et al.* 1997: 1451). The number of sound, untreated teeth decreases with age (Steele and O'Sullivan 2011), which risks bringing the body back into focus in dys-functional ways and requires action to return the mouth to an 'absent presence'.

Shifting the body out of explicit awareness and back to being an absent presence restores body/self connection and allows for increased volition over how it is then managed (Gimlin, 2006). However, the bodies of older people are subject to specific risks of abjection, whereby a sense of self is lost (Gilleard and Higgs 2011; Kristeva 1982). The potential to achieve 'tacit embodiment', giving people 'greater freedom to negotiate selfhood through the body' (Gimlin 2006: 712), may be different for older people who face an ongoing threat of dys-appearance. The ways in which the older body can be worked on both as a means to express self-identity, *and* as something that can dys-appear and cause a 'cleavage between body and self' (Leder 1990: 77), are shaped by discourses and images of ageing. Looking at how older people make sense of their experiences relating to the mouth with teeth offers a lens through which to explore the relationship between body and self in older age.

There has been some sociological attention paid to the mouth (Exley 2009; Gibson and Exley 2013; Kleinberger and Strickhouser 2014), including research focusing on older people (MacEntee *et al*. 1997; Gibson *et al.* 2017). This paper offers an original contribution by bringing together theories of ageing and embodiment to highlight the significance of the mouth with teeth in relation to the construction of a sense of self over the life course. We draw on in-depth interviews with individuals aged 65 and over, in order to explore the narratives constructed around the mouth and teeth, looking particularly at meanings attributed to teeth, feelings about

various forms of artificial teeth and missing teeth, and the work involved in maintaining natural teeth.

Background

Ageing and Embodiment

An embodied understanding of the self encapsulates how the world around us is experienced through the body and then articulated by individuals (Nettleton and Watson, 1998). As individuals become increasingly 'conscious of and actively concerned about the management, maintenance and appearance of their bodies' (Shilling 2003: 4), the body becomes a site which is controlled, worked on and accomplished as part of one's self-identity (Falk 1994; Featherstone and Wernick 1995). Yet for Shilling, there are limitations to this since bodies age and decay, and the fear of what the body will become may be particularly disturbing when a person's identity is centred on the body. Indeed, if the stories we tell about ourselves are always connected to what our body itself is telling us, then sooner or later the continual changes of our body force us to rethink our identity (Randall and McKim 2008: 119–120). At the extreme, we move from a 'third age', as originated by Laslett, (1996), in which, post-childrearing and -employment, we have greater opportunities for self-realisation, to a 'fourth age' of abjection that we can only imagine (Gilleard and Higgs 2011, 2013). What becomes important for researchers is to generate stories '*from* and *with'* the bodies - literally in this case, the mouths - of people at different stages of the life course, 'so that a more comprehensive insight might be developed into how ageing bodies become known and connected through narrative' (Phoenix 2011: 112).

Part of this challenge involves exploring meta-narratives regarding the ageing body that may help to shape people's stories of their mouths. Constructing a body that appears healthy is an

increasing priority, portrayed as an individual moral responsibility (Lupton, 1995). For older people, this is emphasised in the discourse of 'healthy ageing', which positions older people as responsible for engaging in practices to produce good health (Stephens *et al.* 2015). In a consumer culture, the appearance of the body is central (Featherstone 2010). A societal obsession with youthful bodies can pressurise older women in particular to mask or alter physical signs of ageing in order to maintain social power and self-esteem (Clarke and Griffin 2008; Fairhurst 1998; Ward and Holland 2011). The possibility of body modification opens up more choices for expressing self-identity, particularly for women of higher socioeconomic status (Clarke 2011). Yet, the imperative to achieve healthy ageing can normalise interventions on older bodies and change the meaning of ageing 'successfully' (Brooks 2010; Cardona 2008). And again, it is women of higher socioeconomic status who are more likely to have internalised 'healthist norms' that hold individuals morally responsible for the status of their ageing bodies (Twigg 2013: 42)

In contrast, advancing age can be an explanation for caring less about physical appearance and rejecting 'self-invention' (Pitts-Taylor 2003: 34) in order to achieve the body perfect, instead emphasising self-acceptance (Gimlin 2007b; Liechty and Yarnal 2010; Tunaley *et al.* 1999). Nevertheless, varied cultural and social ideas of what it means to be old (Cruikshank 2003; Faircloth 2003; Featherstone and Wernick 1995; Gullette 2004; Katz 2005; Twigg 2015) continue to be inscribed and reinscribed on the body as it moves through the world. Certain bodies, notably Shakespeare's 'sans teeth' (2006: 2.7.1061-1064), represent 'letting yourself go'. The subsequent risk of 'last scene' abjection (Gilleard and Higgs 2011) puts the onus on individuals to continue to manage and discipline the older body (Cardona 2008; Gill *et al*. 2005; Travis *et al*. 2000), often without recognition of the social structures which may hinder their ability to do so (Minkler and Fadem 2002, Victor 2010).

A potential disconnect between subjective and chronological and social age (Laslett 1996) can lead to people feel younger than their age in years, or how they are perceived by others (Featherstone and Hepworth 1991). 'Cosmeceuticals' including teeth whiteners, and rejuvenative procedures such as Botox offer consumer opportunities to display and alter the body to better match one's self-conception, but at the same time they may contribute to that disconnect (Gilleard and Higgs 2013). Indeed, 'age passing' (Cruikshank 2003) can be read as inappropriate, with criticisms of dress (Dumas *et al*. 2005; Fairhurst 1998) or interventions that make faces look 'fake' (Clarke and Griffin 2007), while efforts to satirise passing have been found similarly 'ridiculous' due to their reliance on a conventional lipstick-coated carnivalesque trope (Hogan and Warren 2012; Richards *et al*. 2012). As a result, older people face tensions in working on the body in line with a developing sense of self (Shilling 2003).

As already noted, Leder's (1990) work on the 'absent body' is particularly important for studies on ageing. Leder highlights how the functioning body can be characterised by disappearance; we can forget about the physical body when it is free from pain and disease (forms of 'organic dys-appearance'), and when it does not mark us as in some way 'other'. We most easily forget the body when it looks and acts just like everyone else's. When those alongside us treat us like a fellow subject, another person with a unique consciousness with whom the world can be experienced, the body can be an absent presence. However, an objectifying or antagonistic gaze in another person can be internalised and make us aware of own body ('social dys-appearance'). Our response to dys-appearance is to take action intended to return the body to a state of being an absent presence.

Leder's concept of the absent body recognises everyday situations and ways, beyond dys-functional states, in which the body may be brought into focus, shaped by power relations operating within specific cultural and historical contexts (Gimlin 2006). For Gimlin (2006),

concepts of the absent body and the body as a project are complementary. The dys-appeared body is experienced as other; the response is to work to alleviate this dys-appearance (Leder 1990: 86). However, the aim is not to relegate the body to the 'corporeal background', but to 'restore the body/self connection' in a manner that allows for volition in the extent to which an individual focuses on the body ('tacit embodiment') (Gimlin 2006: 713).

Gimlin's (2006) work puts gender into the picture, recognising women's bodies as amongst those that are regularly fore-grounded due to social inequalities. However, neither Leder nor Gimlin consider age, both as a factor within power discrepancies and in the sense that one's cultural and historical context may change over the life course. Gilleard and Higgs' work suggests that older people are particularly vulnerable to the risk of being forced into the 'limited sphere of the body' (Gimlin 2006: 701). The third age of 'normal' ageing, or 'not becoming old', is characterised by choice, autonomy and self-expression (Gilleard and Higgs 2000; 2010; 2011). In contrast, the fourth age operates as a social imaginary, 'a set of unstated but powerful assumptions concerning the dependencies and indignities of ''real' old age' (Gilleard and Higgs 2013: 369). When people become third persons in others' age-based discourse', they become understood with reference to a fourth age that cannot sustain an interpretation of individual agency (Gilleard and Higgs 2010: 122). This plays out through the meanings attributed to ageing bodies: a key distinction between a third and fourth age is that the latter can appear to be 'nothing but the body', as it is seen to dominate subjective experience (Twigg 2004: 64). The process of making sense of oneself in relation to this feared state (Gilleard and Higgs 2013) can thus involve a focus on functional health and determination that affirms a will to live and emphasises a 'moral identity' (Lloyd *et al.* 2012: 11). Previous studies have shown how continuing to be 'the same person' was given as a reason why a person did not see themselves as 'old' (Clarke 1999; Rozario and Derienzis 2009). In situations involving changing circumstances, individuals adopted 'perseverance' (Lloyd *et al*. 2012), a reflexive process that

allows for adaptation and the continuation of self-identity while keeping on the right side of the 'event horizon' which denotes the fourth age (Gilleard and Higgs 2010).

The Mouth and Oral Health in Older Age

How bodies are marked by an ageing process over time is not straightforward or predictable; individual bodily ageing involves physiological changes, but these are not programmed or inevitable (Westendorp and Kirkwood 2007). Teeth wear away as a 'natural part of life', through exposure to acid, contact with a toothbrush, and grinding of teeth (White *et al*. 2011: 21). Teeth can also be damaged by root decay and become loose through the loss of periodontal attachment, issues typically arising in older age due to the exposure of roots by receding gums and to the cumulative effects of disease (*ibid*.).

Rousseau *et al.* (2014) use the concept of biographical disruption (Bury 1982) to explore the experiences of losing a tooth, suggesting that the relationship between self and mouth could be disrupted by the 'invasion' of dentures, which are often experienced as 'other' to the body. As a consequence, losing teeth can result in a fundamental shift in one's self-identity, and people can struggle to reconcile their sense of the self with the image they see in the mirror (Rousseau *et al.* 2014). While having a gap where a tooth used to be can make someone feel "like an old lady", dentures are also seen as a marker of old age and something that could stigmatise the wearer (*ibid.:* 467, 469).

Proponents of anti-ageing medicine have identified teeth as one of the elements of biological deterioration that should be a site of intervention in order to prevent painful decline (Mykytyn 2008). The commercial market clearly plays on the interplay of health and looks, for example, positioning 'anti-aging dentistry' as a non-surgical facelift that provides 'a healthy appearance'

(https://www.faceliftdentistry.com/anti-aging-dentistry/)[1]. Indeed, decisions to pay for treatments like dental implants, which are closer to 'a normal set of teeth' than dentures, are commonly based on a combination of functional and aesthetic reasons, though with an emphasis on the former (Exley *et al.* 2012; Rousseau *et al*. 2014: 469). Measures of oral health-related quality of life (OHRQoL) confirm that the increased reportage of physical pain and functional limitations in older age groups is not matched by an equivalent increase in psychological discomfort (Nuttall *et al*. 2011). In fact, the social disadvantage (Locker 1988) of self-consciousness and embarrassment relating to oral conditions is more likely to be reported by younger age groups, suggesting there may be 'a difference in expectations, stoicism or values' (Nuttall *et al.* 2011: 12). Yet there has been relatively little qualitative research within dentistry exploring exactly how the mouth and teeth are made sense of in older age.

Exceptions to this include qualitative studies in New Zealand (McKenzie-Green *et al.* 2009), Canada (Macentee *et al.* 1997), the Netherlands (Niesten *et al.* 2012) and Australia (Slack-Smith *et al.* 2009). These studies demonstrate the mouth's potential to shape participants' interaction with others and highlight work involved in as well as value ascribed to maintaining good oral health and keeping one's natural teeth. Older people living in long-term care facilities desired a clean mouth, but deemed teeth and appearance 'not that important' when confronted by other challenges of frailty and institutional life (Donnelly *et al.* 2015: 486). This indicates that the significance of the mouth in older age may vary, flagging the importance of theories of ageing and embodiment in disentangling the complexities of the meaning of oral health in older age and the ways in which older people narrate experiences relating to their mouth and teeth.

Methodology

The research was based in the cities of Edinburgh (Scotland) and Sheffield (Northern England). Participants (n=43) were recruited through social clubs, lunch groups, residential homes, local newsletters targeted at older people, and the University of the Third Age. The convenience sample (Table 1) comprised 15 men and 28 women, all White British, and aged between 65 and 91. A range of education levels and occupations was reported across the sample, though at the time of interview all participants were retired. Individuals were mostly self-selected, their participation unhindered to any significant degree by sensory impairment. However, participants were not recruited where mental capacity was in question since the goal was to encourage a narrative story approach used successfully in previous research concerned with ways in which experiences and attitudes across the life course affect individual circumstances and perceptions in later life (Clarke and Warren 2007) in particular relating to the ageing body (Murray *et al* 2014). Despite recruitment limitations (see Conclusion), the narrative themes discussed below emerged in interviews from participants with very different experiences.

<Insert Table 1 about here>

In-depth, audio-recorded interviews were undertaken with all participants, typically at the participant's home, though in nine cases at another location requested by the participant. Interviews lasted on average 50 minutes, were transcribed verbatim, and then anonymised by the interviewer. Participants were sent copies of their transcript to check accuracy and give them the opportunity to expand on any comments; apart from minor edits in a few cases, no concerns were reported. The project received ethical approval from the lead institution. Prior to the interview, each older person was given an information sheet and had the chance to ask questions about the project. The interviewer obtained written consent from all participants, emphasising that involvement was voluntary and participants could withdraw at any time.

The project aim, explained in fliers, emails, information sheets and verbally, was to learn more about older people's thought on their oral health by talking about experiences to do with the mouth and teeth, and how these have changed over time. Open-ended lifestory interviews (Wengraf, 2001) were designed to capture how older people made sense of their experiences, and their in-process interpretations, providing individuals with the opportunity to talk about what was important to them, rather than imposing set paths (Chambers, 1994). Participants were encouraged to start with their early experiences and move through the life-course, prompted by a topic guide. However, since they were participant-led, at times interviews began with more recent events or moved around time periods. Informed by existing qualitative studies on embodiment, older people, oral health and quality of life (Borreani *et al.* 2010, Gregory *et al*. 2005, MacEntee *et al*. 1997, McKenzie-Green *et al.* 2009, Nettleton 1992) topics covered included looking after teeth, going to the dentist, dental treatments, and everyday experiences involving the mouth, as well as feelings about the mouth and teeth over the life course. Participants of different ages reflected on changes to dentistry through which they had lived, and attested to the impact of particular historical events, consumer interventions, and health programmes including the end of sweet-rationing, mass-marketing of fluoridated and tooth-whitening products, and anti-soft drinks campaigns.

A 'realist tale' approach was taken to the analysis of the interviews attending to both the 'whats' and the 'hows' of storytelling (and retelling), and connecting theory to data in order to allow participants' voices to be heard in context (Phoenix *et al.* 2010). Each transcript was read several times and analytical notes were written, with pseudonyms employed throughout (and extended to this paper). The notes maintained the sequence of the interviews. They identified emergent themes, and reflected on narrative-use within each interview, both across the whole storyline[2] and in brief, bounded sections of interview text in which events and experiences were reported (Riessman 2008) Subsequently, the analysis was able to focus on the capacities of stories, and

the work they did in the context of the interview (Frank 2010). Transcripts were coded thematically using computer assisted qualitative data analysis software, in order to compare experiences across the sample. Attention was given to participants' connections to the wider socio-cultural narratives concerning the increasing salience of the teeth in the maintenance of an attractive appearance, and the body work involved in achieving such presentation. Whilst this kind of structural analysis (Phoenix *et al.* 2010) does not necessarily disregard material conditions, the discussion of findings below concentrates on the participants' expression of identities, perceptions and values through these narrative types, their challenges to dominant narratives regarding the ageing body, and their implications for oral health in later life.

'Mouth talk'

'Mouth talk' captures the ways in which people speak about their embodied experiences relating to the mouth with teeth. Making sense of the mouth in older age involves narrating various experiences. Here, the focus is on maintaining, losing and replacing teeth but elsewhere stories of relationships with dentists over the life course have been reported (Gibson *et al.* 2018), and the concept has been used in explaining self-narratives of family connectedness through family practices and family display (Kettle *et al.* In Press). It is these various narratives, which can be both mundane and empowering, that constitute 'mouth talk'. While narratives are personal, and each person in this research talked about unique experiences, people also draw on 'narrative resources' in order to make sense of their own experiences (Frank 2010). These resources can include recognisable characters, plots and discourses. However, narratives that challenge taken-for-granted understandings of ageing 'allow different body-self relationships to emerge' (Phoenix *et al*. 2010: 3).

Interviews on the 'significance of the mouth in older age' by their very nature elicit narratives relating to the mouth and teeth. Nevertheless, participants also reported on 'mouth talk' in everyday life, in conversations with family members, friends and dental professionals. Looking at the 'what' and the 'how' of these narratives means considering the kinds of experiences that are narrated, and the ways in which these stories are told. Despite the potential to focus on problematic aspects of the mouth and teeth, the majority of participants narrated their experiences in a manner that reinterpreted the mouth so that it could be incorporated into a coherent personal narrative. This included downplaying the impact of the mouth and teeth on their own identity, demonstrating how they engaged in socially appropriate ageing, and maintaining a sense of self through their approach to management of the mouth.

Downplaying the impact of the mouth with teeth

The ways in which older people narrated their feelings about maintaining, losing and replacing teeth – or engaged in 'mouth talk' – often downplayed the impact of the body, demonstrating that the mouth was generally not the thematic focus of people's experience (Leder, 1990). Carol (70) summarised this attitude:

It's just you don't think about your mouth or your teeth until something happens, do you? They're just there like your feet. And you know they're part of life and you fill your mouth and you chew.

In a context in which ageing bodies are seen in terms of decline and decay (Gullette 2004), being in a position not to think about one's teeth seemed to be appreciated. Angela (70) compared her teeth to the rest of her body:

I don't think about my teeth because they are sort of…they're the best functioning bit of me. I mean, I do worry about my eyes because I've got Glaucoma. And I have sort of nothing incredibly major, but I have Fibromyalgia, so my joints ache a lot, and a dodgy back.

Frank (2013) suggests that the body is understood as both a machine comprised of fixable parts and, supporting this, a collection of 'functioning bits'.

The majority of participants noted that they generally did not have many problems with their teeth, and only remembered a few instances when their mouths had specifically impinged on their consciousness. However, evidence was glossed over that could suggest alternative interpretations, such as large numbers of fillings or the removal of teeth. When participants did talk about problems, one means of doing this was through a narrative of 'restitution', a dominant narrative that can be summarised as "Yesterday I was healthy, today I am sick, but tomorrow I'll be healthy again" (Frank 2013: 77). 'Restitution narratives' are not about the self; the role of the narrator is to engage with medical professionals, submit to treatment and to get well:

I started getting very, very bad toothache. The only time I really had a bad toothache and my husband said it must have been bad because I stopped shopping. I was on the point of buying a new coat that I just put it back and said "I can't cope". We rang up a local dentist who said they will see me. So I went down and they extracted it. She said there was nothing she could do. It had to be really extracted […] She just took it straight out and I was fine. (Valerie, 72)

Linking this to the idea of the absent body, such narratives demonstrate the compulsion to act to deal with the dys-appearance of the body (Leder 1990). For this participant, her body was an intrusion in this moment that blocked out other interests. Alleviating dys-appearance through dental work can restore the body/self connection, which gives people freedom to negotiate selfhood through the body (Gimlin 2006). The use of short restitution narratives means that

problems are not the focus of these accounts, which can instead be stories that are about a coherent personal identity.

Participants also demonstrated having the ability to 'manage' or 'cope' when they had lost teeth and not engaged with dentists in order to replace them. While not intervening to alleviate the dys-appearance of the body, eating practices adopted to deal with missing teeth could be part of bigger pictures of the self. Ted (71) spoke about not being able to eat anything hard, and managing by removing pie-crusts, cooking vegetables until they were like a 'pulp' and sucking breakfast biscuits. Although he talked about lots of foods that he did not like, he kept reiterating the point that he would 'eat most things but not if it's too hard'; this was not about being 'a fussy eater'. Ted repeatedly stressed having enjoyed a good life, and being 'grateful'. He had changed his eating habits and constantly referenced finding means to 'manage' in order to maintain a sense of identity of someone who was grateful for what he had, and avoid his mouth becoming an 'object of pity or disgust' (Leder 1990: 82). Across the sample, participants explained problems relating to the mouth and teeth in ways that allowed them to be the 'same person', rather than changing in a manner that might mark one as 'old' (Rozario and Derienzis 2009).

Those who more regularly thought about their mouths and teeth reported health concerns, functional problems, perceived issues with appearance or worries about visiting the dentist. The painful or problematic mouth could 'dys-appear', due to difficulty eating, for example:

> But my teeth, they do worry me a bit now because I am restricted. I eat more slowly. I cut my food up into very small pieces so it takes me longer to eat. (Doris, 83).

Glossed over by some participants, eating difficulties were one of a number of problems that appeared to be overwhelming Doris whose 'realist tale' was more chaotic (Frank 2013). The

mouth could also be brought into focus through the comments of others, such as grandchildren asking about ‘yellow’ or ‘dirty’ teeth, or dentists who indicated a participant’s mouth or teeth were somehow worthy of comment. As Leder (1990) suggests, the body is most forgettable when it looks and acts like everyone else’s, and to draw attention to the mouth or teeth as somehow different can work to mark these as ‘other’.

Participants also made sense of themselves in relation to ideas of being ‘old’, which operate as a social imaginary marked by a failure to maintain agency and in which the body comes to dominate social experience (Gilleard and Higgs 2013). Several participants cited ‘old’ people they knew who had ‘let themselves go’, and they were used to illustrate status that the participants did not want to acquire. One spoke about a woman she knew with bad breath:

But this old lady, I think it's just old age. It really is old age. And she's probably neglected her teeth. You know she's got so much wrong with her. She can't be bothered with her teeth. (Beryl, 82)

Another participant, Rose (80) spoke about what she saw among ‘a lot of old people’ who have ‘let themselves go’ and whose teeth look ‘dishevelled’. She explained that this would bother her, and distanced herself from this, talking about the importance to her of looking presentable, being able to smile and having a ‘decent set of teeth’.

Being seen in this way was a concern for other participants, for example, Yvonne (66) described her dislike for own ‘crooked’ teeth and what this meant to her:

I think if you’ve not got nice teeth it makes you look old. You know, you can have grey hair, well, you can colour it, but I can’t do anything about my teeth and I would really like to, but it just isn’t practical. So, I feel that makes me look, or labels me as old when I don’t want to be.

She defined this as ‘old in the sense of you don’t do anything, don’t go anywhere, you sit in a chair.’

While not having teeth ‘fixed’ could be read as a sign of old age defined in terms of passivity, age-related differences within particular encounters, and especially the cultural prevalence of white teeth, could make participants more aware of their mouths and teeth and what was different about them. For Pauline (68), the changes to her mouth, such as receding gums, discolouration and increasing dryness, represented an ageing process that she found ‘frightening’ and ‘upsetting’:

I don’t want to smile, I don’t want to do a lot of things because of it. And because of the obsession with having nice teeth, I used to have them like you, it makes it even worse.

Pauline recognised that this permanent dys-appearance of her mouth marked her as older:

…there’s only one way, when they’re going to go, they’re going to go. You know because I'm getting older and, you know, it's like…they're not going to be like when I was 17 or 18 anymore.

The worry of losing front teeth meant that ‘not thinking’ about her teeth was not an option. For a small number of participants, multiple oral health problems meant the mouth remained the thematic focus of their experiences, and rather than illustrating successful restitution, their narratives were more chaotic (Frank 2013); in Pauline’s case, a dry mouth and discoloured teeth were ongoing problems that left her in a situation of uncertainty about the best course of action. Nevertheless, other participants with oral health problems found ways to deliver more agentic stories, as we will demonstrate in the rest of this paper.

Demonstrating appropriate ageing

Participants made reference to taken-for-granted understanding that ageing appropriately involved 'making the best of oneself', and to striking a balance between not being overly focused on appearance, but taking care of oneself overall in order to maintain good health, stay active and be able to realise one's potential (World Health Organisation 2002). This reflects the ideas of 'healthy ageing' outlined above (Stephens *et al*., 2015). Thus some spoke about accepting changes to the mouth that were simply aesthetic, and a need to 'put up' with things like discolouration of teeth and fillings in order to avoid further damage to ageing teeth:

As for these days, people whiten their teeth and have them bleached. But when you get older and your enamels are wearing out, it's not a good idea to have them bleached. You have to put up with this I'm afraid. (Valerie, 72)

I've got [a filling] here that is discoloured but the dentist is a bit loath, because she said each time you need to put another filling, when you have a filling, you have to drill a bit of the tooth away. So, I'm putting up with that, looking a bit darker than I want. (Wendy, 77)

For several participants, how their teeth looked was less important than keeping their own teeth, so avoiding further damage was prioritised. As Gregory *et al.* have argued, people construct 'margins of relevance', including positioning of authenticity and positioning of character (2005: 1863). The admiration of healthy, natural teeth allowed for self-narratives that illustrated 'appropriate' priorities for older age.

The value of looking 'natural' (Clarke and Griffin 2008) was emphasised here, often in contrast to 'shiny white' or 'ultra-white' celebrity teeth. Participants saw whitening as 'ridiculous' for someone of their age: 'At 84 you would not expect my teeth to be perfect, shiny white, would you?' (Florence, 84). Overly white teeth were also criticised in others; David (73), spoke about

the ‘brilliant’ teeth of his sister-in-law, but evaluated her choices by commenting that ‘in a 70 year-old they don’t look right’, because ‘every one has been capped and it’s been capped with big and bright, you know, the whitening. It’s aesthetics gone mad’. Maintaining one’s own teeth, even if these did not look ‘perfect’, was seen as an achievement, both for participants and those they knew.

As in other research (Clarke 2001; Liechty and Yarnal 2010), some participants demonstrated increased self-acceptance and spoke positively about not being embarrassed, and caring less about what others thought, as long as they felt ok in themselves. For example, one participant had dentures that moved and had dropped on a few occasions, but ‘what would have embarrassed me mightily in my twenties, thirties, forties and even fifties, I don’t care now’ (Karen, 70). Demonstrating self-acceptance often involved highlighting a lack of problems; as long as their teeth were functional and not painful, participants accepted things potentially perceived as problematic by others; it could be a ‘benefit of getting older’. Nevertheless, this wasn’t always the case as participants were still aware of their appearance, and as mentioned above, wanted to avoid looking ‘old’. Participants conceded that changes to the mouth and teeth were understood in terms of both broader cultural ideas about ageing and embodiment, and personal stories that illustrated a sense of self.

Maintaining moral identity and sense of self

Getting on with it

Several participants presented themselves as someone who could, and had, dealt with the wide range of difficulties life had thrown at them. Lloyd *et al.* (2012) have used the idea of

'perseverance' to capture older people's narratives of adapting to changing circumstances. Similarly, here participants talked of 'getting on' with things:

Well, I mean if you go to the dentist and he says, "Well, I'm going to have to give you three injections because I'm going to take that tooth out." I don't say, "Oh dear, I can't cope with that." I just say, "Let's do it. Get on with it." (Roy, 67)

Other participants spoke of 'taking things as they come' or alluded to not dwelling on regrets, such as choosing to have teeth taken out rather than filled as a teenager. Instead, they persevered with dentures because they saw them in the wider context of good oral health, and indeed good health more generally.

How participants 'got on' with things was articulated through body work (Gimlin 2007a) and acceptance of dental treatment that involved significant restoration. The so-called 'heavy metal generation', born between the 1930s and the 1960s, has experienced high levels of decay, which was treated by fillings and other restorations (Steele 2009). Participants who had 'loads' of fillings focused on how they had managed to maintain their teeth over the life course, often in contrast to parents or a generalised previous generation (Kettle *et al.* In Press).

Accepting high levels of restorative work as 'normal' reflects changing experiences of dentistry and forms of body work that are taken for granted among particular cohorts. Participants did not want to be seen as complaining unnecessarily, and again there appeared to be a moral imperative to demonstrate appreciation in their approach to life. Carol (73) illustrated this with a particular memory:

But yes, I suppose compared with some folk, I've been quite lucky. I remember one young woman who'd got a horrible, horrible tumour. So she'd had to have most of her face removed. […] it was just absolutely awful. And I just thought well compared with that, I mustn't complain when I get a bit of toothache.

Carol wanted to be someone who thought positively about her OHRQoL. MacEntee *et al.* (1997) suggest that older people can adapt to poor oral health, and adaptation strategies often involve comparisons with other disabilities as well as other people. In the context of self-narratives, similar comparisons made by participants represented a way of maintaining a moral identity over the life course.

Willingness to work at maintaining teeth

The concept of 'tacit embodiment' allows for autonomy over the extent of work done on the non-dys-functional body (Gimlin 2007). Gilleard and Higgs (2010) suggest that being able to demonstrate such autonomy positions one within the third age, rather than subject to the abjection of the fourth age. In keeping with this, narratives emerging over the course of an interview often centred on the concern to maintain or 'hang on' to natural, albeit restored teeth and thus preserve a part of one's identity (Niesten *et al*., 2012). Dentures were something to be avoided, reflecting the potential for a disruption to a sense of self identified by Rousseau *et al.* (2014).

Maintaining natural, replaced or restored teeth was a life-course project, which involved long-term relationships with dentists[3] and substantial body work, and allowed older people to retain a strong body/self connection. Here participants demonstrated moral responsibility for oral health through willingness to work at, and incorporate new practices in maintaining their teeth. Eileen (70) had not been aware of gum disease and the function of interdental brushes but having been

told about correct dental hygiene, she was keen to engage in what she understood to be necessary dental care:

So now I TePe[4] my teeth morning, night, and after a meal and it's just commonplace. [ ]So it just, it shows, doesn't it, that if you're given information and you're treated with respect, then the work is mine, which is how it should be because they're my teeth. I take responsibility for them.

Her 'day in, day out' adherence to this new regime fostered Eileen's hope that she would keep most of her remaining teeth.

Valerie (72) talked about the 'intense' practices involved in looking after and preserving teeth:

I would hate to think that I have to have them removed because of gum problems as you get older so that's my biggest worry now, gums not teeth… I've got an electric toothbrush, floss, dental brushes, and mouthwash. So, yeah. It's quite intense. It takes forever. But no, it's something that you're just happy to do.

Aware of the possibility that gums might recede and the passing of time impact on restorations and dentures, participants constantly reiterated the desire to retain their own teeth and associated identity. They demonstrated a clear willingness to invest time, effort, and money to stave off the ever-present threat of dys-appearance (Gimlin 2006) and, having resolved problems, they reframed dental interventions in a fashion that allowed them to return to a project of active ageing and uphold a sense of self.

The participants quoted above spoke of actively choosing to engage in intensive oral health practices in order to maintain their teeth in older age but had the resources to do so. Eileen

(alongside others) recognised the likely consequences of no longer being able to afford dental treatment:

I'd do anything to keep my teeth without a shadow of doubt. But then if it became so expensive or I couldn't afford it or variables, usually has to do with the economics, I would have to have false teeth I suppose which I would loathe.

While many participants in this study had worked in professional or managerial occupations, the potentially prohibitive cost of dental treatments was noted in several interviews, and two working-class participants recalled not going to the dentist for periods when it was too expensive. Previous research has identified the cost of dental treatment as a barrier to the use of oral healthcare services among older people (Borreani et al., 2010), so it is important to recognise the relatively high socioeconomic status of the majority of our participants who did not feel excluded from the social world of organised dentistry and consumer oral care (Gibson *et al.* 2018). Furthermore, working to maintain one's own teeth at a substantial cost, rather than having all one's teeth removed and replaced by dentures could reflect an intergenerational shift in values. Colin (87) described his parents taking advantage of free teeth as a 'silly reason' for getting full dentures and spoke about investing in private dentistry 'because I'm so keen about keeping my teeth'. Other participants linked their oral health in older age to their education and access to dentistry over the life course, indicating the importance of situating accounts of willingness to engage in oral healthcare in this socioeconomic context.

Reframing dentures and missing teeth

Preserving one's teeth through body work could be a source of pride, but equally the loss and/or replacement of teeth could become part of a story that challenged a taken-for-granted narrative

of decline (Gullette, 2004; Phoenix *et al*., 2010). Participants with full or partial dentures, or dental implants, framed this experience as positively as possible by emphasising their naturalness: 'Some people thought I had my own' (Betty, 70), or by 'normalising' their denture: 'I've got so used to it now, I don't even think about it' (Sandra, 67). Dental appliances became part of a personal identity in progress rather than an 'alien' presence (Rousseau *et al*., 2014). However, this could take some time and although the restoration or replacement of teeth could work to alleviate problems and reinstate a body/self connection (Leder 1990), failing restorations or problems with dentures could cause the mouth to dys-appear and intrude on day-to-day life. One participant recounted an experience when her crown fell out on holiday and how she felt:

Terrible, because it was...you know it was...that was right at the front, you know. It's that one [indicating] that's a crown, so you know I was going to try not to open my mouth. (Josephine, 79)

This demonstrates a difference between participants; while some accepted visible gaps (as we discuss below), others were more self-conscious about the social dys-appearance of their mouths. The potential for such disruption meant that participants concentrated on how they could maintain teeth, and concomitantly long-lasting restorations were seen as an accomplishment.

Reframing did not solely apply to dentures and implants, however. Accounts of not replacing teeth were also used by participants to illustrate their wider values and approach to life, despite missing teeth commonly being read negatively as 'old'. For example, Connie (83) highlighted that spending thousands of pounds on replacement teeth did not fit with her priorities more generally:

Well, when I had that one out [pointing to missing front tooth] I thought "It's not awfully pretty, I'll have one screwed in" and then I thought, "Oh, I've got a screw in there, I'll have a screw in there, I'll have a screw in there [gesturing to other gaps], that'll be nice," but then I found out how much they were and I

thought "This is ridiculous, other people need food more than I need, screw teeth, better give the money to Oxfam than that."

Connie positioned herself as someone who did not care how she was viewed by others, so was able to maintain a moral identity on the basis of her priorities: 'it seemed rather wicked to spend that amount of money on myself and not give it to people who needed things more than I needed a tooth'. She framed worry about visibly missing teeth as age-related: 'Forty-three, I might've done, twenty-three probably certainly would've done. I'm not going to worry about it at eighty-three'. This suggests that at certain stages, it may be more 'appropriate' to focus on health and wellbeing than appearance.

The notion of naturalness was again engendered by participants but in this case as a justification for not pursuing medical intervention. William's (69) self-declared suspicion of medical advice, chemicals, including fluoride, and by association, 'cleaning the teeth too often' stemmed from when he 'started to inquire more about what really goes on in the world and the trickery at a political level'. His preference for 'natural' ways of doing things extended to the use of a neem stick[5] that 'does certain jobs better' than a toothbrush. William was 'happy' to have his own teeth, and wanted to keep them for as long as possible. Nevertheless, when a tooth split and his dentist suggested a crown, he decided against this:

And then I thought I can manage with a hole now. I don't really want anything unnecessary in my mouth. So I've still got a hole. I've still got a gap I mean. So I never had anything done about that.

William's rejection of a crown as 'unnecessary' and 'artificial' fit with his broader identity as someone who valued what was 'natural' and questioned the received wisdom within dentistry. Like Connie, he indicated that he could afford these treatments, but chose not to replace missing teeth for ideological reasons.

Other participants demonstrated the ability to use humour to resist becoming objects of pity as a result of moral judgements applied to those with missing teeth (reference). Kevin (65), had broken one of his front teeth as a child, and while a brace had been used to move another tooth across to fill the space, he still had a visible gap. When asked about any concerns, he responded:

The only thing that has crossed my mind is probably having this one took out and two put in to look normal but then I thought, I'm still going to look an old man anyway, so why…Why do I want to look an old man with good teeth [laughs] when I'm an old man with teeth that work?

References to looking 'normal' could be seen to indicate a narrative in which the participant's body was brought into focus as problematic. However, echoing Karen's observations about appropriate ageing, Kevin talked about how, with the passing of time, he had developed more confidence and become less concerned about what others thought:

But as I got older, I realised that any imperfections that anybody's got, you only tend to see them yourself, other people don't notice it.

Being able to illustrate this wryly worked to frame his experiences overall in a positive mode.

For others, accounts of not replacing teeth were explained in terms of the personal importance of prioritising function and health over aesthetics. Beryl (82) related how she made a decision to no longer wear some false teeth:

I did have some false ones, but they were on a wire, and I had to push them up on the other teeth. And when I used to clean my teeth, take those out to clean my teeth, I used to think, "Those wires aren't doing those teeth any good." So, I stopped using them.

While for Beryl gaps were effectively the result of false teeth with which she was not happy, again the suggestion was that this was not personally important: 'I could just eat without. So, it didn't matter'. Despite a notable change to her appearance, particularly to her teeth that had been 'the best part of me', her positioning of this as something that 'didn't matter' demonstrated that Beryl had the agency to reframe tooth loss and avoid the experience of having 'no chosen choices' that characterises the fourth age (Gilleard and Higgs 2010).

Conclusion

In this paper, we have argued that sociological theories of ageing and embodiment can help us understand 'mouth talk', in this case comprising older people's accounts of maintaining, losing and replacing teeth. Problematising the ageing mouth with teeth, and the role it plays in everyday life, adds to existing sociological literature that demonstrates how various embodied practices can be used to negotiate ageing. Teeth offer an interesting example, being both the object of dental practices understood in terms of oral health, and a body part subject to age-based stereotypes. Older people's stories relating to the mouth and teeth reflect on the relevance not only of appearance, but also function and the presence or absence of pain and, in turn, help us to understand the complexities of ageing (Phoenix *et al.* 2010).

Previous literature on the embodied experiences of ageing has pointed to the tensions involved in managing the body as part of one's self-identity. The moral imperative to aspire to healthy ageing and not to 'let oneself go' calls on older people to continue to work on the body. In relation to the mouth with teeth, maintaining good oral health involves following the recommendations of dental professionals and subjecting oneself to body work when problems do

emerge. Accounts of fixing such problems, and returning the mouth to an absent presence, took the form of restitution narratives (Frank 2013) in which stories are told by a self but are not about the self. In these instances, the body, or parts of the body, temporarily dys-appear and action is taken to address this (Leder 1990). Experiences such as multiple fillings or the loss of teeth were glossed over. Whether big or small, stories constructed during interviews were framed to emphasise an overall lack of (unresolvable) problems. Where attempts to manage the mouth with teeth were less successful, and the mouth remained in thematic focus, this resulted in chaotic stories characterised by multiple problems and a lack of certainty about the future.

'Mouth talk' also worked to illustrate a continued sense of self and a particular moral approach to life, demonstrating appreciation for one's situation, or willingness to invest time and effort to achieve a desired goal. In some cases, the mouth with teeth could be seen as a project (Shilling 2003); the retention of natural teeth an achievement tied to one's identity and, by implication, a challenge to the dominant normative discourse of decline (Gullette 2004). As teeth are assessed in different ways, the margins of relevance may change over time (Gregory *et al*. 2005) with priority given to maintaining natural teeth rather than valuing 'straight, white teeth'. Participants' accounts of working on their bodies allowed them to exhibit a moral responsibility for oral health. Although the data were far from conclusive, if there were gender differences they played out here, with women participants telling more detailed stories of body work which was linked to appearance while men were more likely to focus on restitution narratives and staying natural or the same person. Either way, being able to work on one's body in these empowering ways presupposes having the financial resources to do so, and this finding may reflect our predominantly middle-class sample.

Participants' experiences involved ongoing restoration, loss and replacement of teeth, as maintaining natural teeth over the life course was not straightforward. The 'gradual decline' of

bodies makes it increasingly difficult to find means of 'rejuvenating the physical flesh' (Shilling 2003: 189). This suggests that seeing the body as a project is less relevant in older age, as the possibilities for working on the body and body options decrease over time. There are limitations to how the 'developing conception of self' (*ibid*.: 187) can be expressed through the body, and individuals' concern with the everyday management of health and mobility may grow (Warren 2018). Narratives of ageing become framed by the social imaginary of 'real old age', characterised by a loss of self-identity and a body that dominates subjective experience (Gilleard and Higgs 2013). However, this paper argues that the mouth with teeth is reinterpreted over the life course in ways that allow for a coherent personal identity to be expressed through 'mouth talk' (for example, describing oneself as being someone with particular values or who approaches life in a certain way). A narrative perspective highlights how embodied practices such as oral care at home, eating and drinking, and engagement with dental treatment can be incorporated into a sense of self that is continually in process.

Of course, there are potential limitations to the study. Though not an inconsiderable sample size, the findings cannot be considered definitive. As might be expected numerically in a group of people aged 65-91, women outnumbered men by roughly 2 to 1. The sample was uniformly White, and predominantly tertiary-educated and middle class, having worked in managerial or professional roles. A more diverse group across class, ethnicity and location (including migrant status) might have generated different perspectives. The keen responsibility to uphold the duty of self-care, which has been noted in relation to Western women of high socio-economic status (Twigg 2013), may not be mirrored by individuals from cultures/societies that are ungoverned by such healthist norms or unable to meet the associated expenses. Further, the notion of the fourth age – abject or not (Gilleard and Higgs, 2011) – may not be meaningful for certain groups, such as those living in poverty who believe old age starts earlier than those in a better financial

situation (Abrams *et al.* 2015). Capturing stories from a wider range of participants clearly justifies further research.

Whether ultimately individuals focus on the fourth age or not, what is clear from the study is that listening to narratives offers a way to recognise the priorities of older people in relation to their mouths and teeth. Mouth talk itself reveals varied and varying stories, extending beyond mouth and teeth in and of themselves to incorporate what we do with them and how they connect us with others. In this sense, the concept as a body metaphor (Turner, 1991) offers huge potential for future interdisciplinary development. Here, recognising the social and cultural context of 'mouth talk' allows us to consider how a personal identity can be maintained, despite the loss or replacement of teeth that can be read as 'old'. Continuing to make sense of the mouth with teeth in relation to a sense of self, whether through demonstrating the achievement of maintaining teeth, reframing the loss of teeth or illustrating a moral approach to the replacement of teeth, represents 'perseverance' (Lloyd *et al*. 2012) and effectively works to resist the objectification associated with the fourth age.

Words = 9,0002

NOTES

[1] Accessed September 2018.

[2] Phoenix *et al* (2010:5) summarise general types of cultural storylines that can shape and frame an ageing person's personal story as including the regressive, progressive, crossroads, career, U-curve, and wheel.

[3] See the section on 'Mouth Talk' (p12) for details of the publication in which narratives of the 'good' dentist/patient relationship are explored in depth..

[4] TePe is a brand of interdental brush.

[5] A neem stick is a teeth cleaning twig used widely in India.

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TABLE 1. *Overview of participants*

	Male	Female		
Gender	15	28		
	Sheffield	Edinburgh		
Location	33	10		
	65-69	70-79	80-89	90 – 99
Age	11	20	11	1
	Married/ LAT	Single	Divorced	Widowed
Marital status	16	2	11	14
	School education	Further education/ training	Higher education	
Education	10	14	19	
	Routine	Intermediate	Managerial/ Professional	
Employment	7	9	27	
	Yes (limits a lot)	Yes (limits a little)	No	
Disability or longer-term health condition that limits life on a day-to-day basis	10	6	27	
	Every 3-4 months	Every 6 months	Every 12 months	Problems only/no longer goes
Regularity of visit to dentist	1	25	9	8